Luminous COUNSELING

CONSENT FOR OBSERVATION

PURPOSE OF OBSERVATION

This consent form is designed to obtain your permission for an individual to observe your therapy session. The purpose of the observation is to enhance the training and supervision of health professionals and improve the quality of care provided. The observer may be a trainee, student, supervisor, or another authorized individual. Observers are bound by strict confidentiality agreements and are trained to respect your privacy and the sensitive nature of the information shared during therapy sessions.

CONFIDENTIALITY

Your confidentiality is protected by HIPAA. All information shared during the therapy session, including observations made by the observer, will remain confidential and will not be disclosed without your written consent, except in the circumstances defined in the informed consent signed at intake.

USE OF PERSONAL HEALTH INFORMATION (PHI)

The observer will not have access to your personal health records. The observer will only be present to observe the session and will not document or record any information about you outside the context of the observation. Any notes taken by the observer will be de-identified and used solely for educational and supervisory purposes.

YOUR RIGHTS

As a client, you have the following rights:

1. The right to refuse consent for observation without affecting your treatment.
2. The right to withdraw your consent for observation at any time without penalty.
3. The right to ask the observer to leave the session at any time.

OBSERVER'S INFORMATION

OBSERVER NAME

AFFILIATION (e.g. school, company)

ROLE (e.g. trainee, student, supervisor)

EMAIL ADDRESS

SARAH SHINE, LCSW, LISW-CP • LUMINOUSCOUNSELINGJOURNEY.COM
Florida SW20140 · Georgia CSW009004 · South Carolina 6508

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CONSENT FOR OBSERVATION CONTINUED

VOLUNTARY CONSENT

Your participation in therapy and consent for observation are voluntary. You have the right to withdraw your consent for observation at any time without penalty.

CONTACT INFORMATION

If you have any questions about this consent form, your rights, or our HIPAA compliance practices, please contact us at:

EMAIL SARAH@LUMINOUSCOUNSELINGJOURNEY.COM
WEBSITE LUMINOUSCOUNSELINGJOURNEY.COM
PHONE 904.446.8691

By signing below, you acknowledge that you have read and understood the information provided in this consent form and agree to allow the specified individual to observe your therapy session under these terms.

CLIENT SIGNATURE

CLIENT NAME (PRINTED)

DATE

OBSERVER SIGNATURE

OBSERVER NAME (PRINTED)

DATE

THERAPIST SIGNATURE

Sarah Shine, LCSW, LISW-CP

THERAPIST NAME

DATE

Thank you for your cooperation. We are committed to providing you with the highest quality of care and ensuring your privacy and confidentiality.